DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814

March 28, 2001

ALL-COUNTY INFORMATION NOTICE NO. I-24-01

TO: ALL COUNTY WELFARE DIRECTORS
ALL IHSS PROGRAM MANAGERS

Reason For This Transmittal

[X] State Law Change
[ ] Federal Law or Regulation Change
[ ] Court Order or Settlement Agreement
[ ] Clarification Requested by one or More Counties
[ ] Initiated by CDSS

SUBJECT: **CURRENT STATUS ON THE CONVERSION ACTIVITIES FOR THE PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY FOR SHARE-OF-COST (SOC) OF IN-HOME SUPPORTIVE SERVICES (IHSS) RECIPIENTS**

REFERENCE: All-County Letter (ACL): 99-25

The purpose of this All-County Information Notice (ACIN) is to provide counties with an update of the ongoing expansion of the Medi-Cal PCSP to eligible aged, blind, and disabled medically needy. The expansion, which provided Medi-Cal coverage of most IHSS services to Medi-Cal beneficiaries who were previously income ineligible, was authorized in Assembly Bill (AB) 2779 (Chapter 329 Statutes of 1998), and was to be implemented April 1, 1999. A future ACL will serve as a basis for counties to establish a procedure to ensure the exchange of information between the Medi-Cal Eligibility Data Systems (MEDS) and the Case Management Information and Payrolling System (CMIPS). That ACL will address implementation instructions concerning IHSS. The California Department of Health Services (DHS) will be providing a similar letter concerning the conversion.

Overview

In order to implement the conversion of income eligibles (IE) to PCSP, the California Department of Social Services (CDSS) brought together a workgroup of State and county staff. The workgroup met on several occasions to resolve conversion difficulties, CMIPS reprogramming, development of a universal eligibility form for IHSS and Medi-Cal workers, new Notice of Action (NOA) language, and directions pertaining to SOC calculations.

Revision to the Statement of Facts for In-Home Supportive Services (SOC 310)

Under the IE to PCSP conversion, the workgroup recognized that the legislation mandates two SOC determinations for Medi-Cal beneficiaries receiving IHSS/PCSP services.

The law that extended Medi-Cal coverage to IHSS beneficiaries with a SOC also required that the lower of the IHSS and Medi-Cal SOCs be paid by the recipient for the Medi-Cal case. The information needed for one determination (such as income and property of the applicant) is also needed for the other determination as well. For example, Medi-Cal eligibility may be based on information gathered on Form SOC 310. Given the pending implementation, the counties are to record the information for all new applicants.

In order to accomplish the required SOC determinations, the workgroup agreed to use one universal form. The workgroup decided that a revision to Form SOC 310 would meet this requirement. This revised form has changed **Question 12 from "*24*" *months* to "*36" months*** and changed the age limit for Medi-Cal recovery purposes from ***"65***" to ***"55"***. We have also added an additional question requested by the June 15th meeting of the IE to PCSP workgroup. This ***new Question 18*** asks whether the recipient, spouse, or parents had medical expenses within the last three months and desires Medi-Cal for those expenses? ***Question 19, as renumbered***, was also changed to provide a space to enter the premium amount on the form. The completed and approved form will be available in the five threshold languages.

SOC Calculation

Counties are reminded that the buy-out and retroactive period is effective from April 1, 1999 and counties are responsible for determining the SOC difference from that date. This is necessary to accurately claim federal financial participation. As previously noted, AB 2779 provides a state general fund "buy-out" of the difference when the Medi-Cal Program SOC is higher than the IHSS SOC. Because a recipient is to pay the lowest SOC, each county must calculate two SOCs, one using the IHSS program rules and one using Medi-Cal rules. The DHS budget provides for the county's administrative costs associated with determining the Medi-Cal SOC and counties must file a Medi-Cal claim with DHS to obtain reimbursement.

Counties must compare the two SOC calculations, so that the lower of the two may be assigned to the recipient. When the Medi-Cal Program SOC is greater than the IHSS SOC, the State will pay the difference to the federal government (the "buy-out") and the recipient will receive personal care services.

From the perspective of the recipient, AB 2779 results in the "buy-out" recipient paying the lesser of the IHSS or Medi-Cal SOC when the Medi-Cal SOC is higher. In those rare instances when the IHSS SOC is greater than the Medi-Cal SOC, CDSS may authorize a retroactive reimbursement to these recipients for the difference, as if it were an underpayment, from the State General Fund. The reimbursement is to be issued to

the recipient in the full amount of the calculated underpayment. A separate ACL will be provided with instructions for reporting this difference.

At this time, the feasibility of creating two special transactions is being evaluated. These special transactions would have codes that enable counties to report the difference in the two SOCs and to identify whether a payment to the recipient has been generated or an amount needs to be paid to the federal government.

The SOC comparison is a relatively easy process when making a determination for a single individual. It is also easy if the beneficiary is not eligible for the residual program, as only the Medi-Cal SOC would be calculated and applied to the case. However, the comparison becomes problematic when contrasting the SOC for an individual calculated under the IHSS program rules to the Medi-Cal SOC for a Medi-Cal Family Budget Unit, of which the recipient is a member. CDSS received guidance from DHS related to the conversion of certain IHSS program recipients to the Medi-Cal PCSP. Determining the applicable Medi-Cal SOC for a recipient who is part of a Medi-Cal Family Budget Unit remains complex. Agreement has been reached on this aspect and directions will be given to the counties in a separate ACL so that the "buy-out" or reimbursement determinations for all recipients can be made.

A&D FPL Impact

Welfare and Institutions Code §14005.40, created the Aged and Disabled Federal Poverty Level (A&D FPL) Program. Recipients who were eligible for services with a SOC through the IHSS IE to PCSP shift as of April 1,1999, may receive eligibility without any SOC through the A&D FPL Program, implemented January 1, 2001. Even though such individuals will have no SOC as of January 1, 2001, records nevertheless need to be maintained to determine the respective "buy-out" or reimbursement from April 1, 1999 through the month the recipient is converted to no SOC under the A&D FPL program. As discussed above, SOC records for individuals not qualifying for the A&D FPL program, but eligible for services through the IHSS IE to PCSP shift, must continue to be maintained even after January 1, 2001.

Case Management, Information and Payrolling System (CMIPS)

The process has been initiated to order the changes to the CMIPS to allow three new tracking codes for PCSP. These tracking aid codes are expected to be transparent to the Medi-Cal and IHSS worker. **The following codes should not be used until changes to CMIPS are made.** The new codes are:

- 1F, for beneficiaries age 65 years and older,
- 2F for blind beneficiaries,
- and 6F for disabled beneficiaries.

The CMIPS conversion will also allow for the placement of four new fields to the RELB screen, somewhere on the K line.

- The first new field will reflect a whole family group's SOC and be identified as the Medi-Cal "Family Budget Unit" SOC from MEDS that is input by the county.
- The second new field will reflect an identifier to indicate whether the MEDS SOC entered is for a multiple member of a Family Budget Unit or an individual.
- The third field will reflect and identify the individual's apportioned amount of the Medi-Cal Family Budget Unit SOC input by the county that is being applied toward the individual IHSS case when there are linked spouses/companion cases.
- The fourth field will reflect, and be identified as the IHSS equivalent of the MEDS Family Budget Unit SOC for linked spouses/companion cases.

CDSS will issue specific CMIPS instructions under a separate ACL once changes are made to CMIPS.

NOAs

NOAs will address when a person's IHSS SOC is lower than the Medi-Cal SOC; in circumstances where there is a reassessment and the outcome changes a computed and paid SOC, and when a recipient is no longer PCSP eligible but is still obligated for the IHSS SOC. At this time, the plan is for DHS to ask Medi-Cal workers to suppress Medi-Cal notices for the Medi-Cal Family Budget Unit in which the PCSP beneficiary receives eligibility. Medi-Cal SOC information will be forwarded to the IHSS worker for inclusion in the notice sent for the PCSP case. This necessitates the establishment of new NOAs to meet the new requirements for the converted population. The IE to PCSP workgroup provided input into the design requirements for these NOAs. DHS is presently reviewing their NOA requirements in relation to the IE to PCSP shift. The NOAs will be finalized after review by the IE to PCSP workgroup.

Remaining Implementation Issues

Remaining issues that need to be resolved before this process is complete include:

- Design and distribution of instructions for the K-line changes to CMIPS and Form SOC 293;
- Ramifications of AB 2779 upon individuals having a higher IHSS SOC than their Medi-Cal SOC.

Financial Reimbursement

Counties have been previously directed to make the entries necessary to start the federal financial reimbursement process. ACL No. 99-25, dated April 19, 1999 and Electronic Bulletin Board 99004, dated February 26, 1999, informed counties of the requirement to key the PCSP provider eligibility flag on the PELG screen in CMIPS. Where a recipient is identified as having PCSP authorized hours, counties enter a "Y" in the PCSP field on line "ZZ" of the RELC screen.

The CMIPS' PELG screen provides information regarding the provider. When a recipient is receiving PCSP authorized services from a spouse (or from a parent, if the recipient is a minor), then no federal financial participation is provided. When PCSP services are from a spouse (or from a parent, if the recipient is a minor), a "N" is entered in the "PCSP" field, at line H2, of the PELG screen in CMIPS. After the information is input on the PELG screen, the "PCP ELG" information over prints on Form SOC 311, turn around document, which then reflects whether the individual's provider is a PCSP provider.

When a recipient is receiving PCSP authorized services and someone provides the services other than a spouse, (or a parent, if the recipient is a minor), then federal financial participation may be claimed. When PCSP services are not from a spouse, (or from a parent, if the recipient is a minor), a "Y" is entered in the "PCSP" field, at line H2, of the PELG screen in CMIPS.

Thus, an entry of "Y" in the PCSP field on line "ZZ" of the RELC screen and an entry of "Y" in the "PCSP" field at line H2 of the PELG screen identify the PCSP recipient as receiving services from a PCSP provider for which federal financial participation may be claimed. Because the CMIPS intends to use these two fields for recognizing potential individuals available for the IE to PCSP conversion, proper entries of information in these two fields are crucial.

Counties have up to 24 months to claim for federal financial participation for any month in which service is rendered. We are nearing the end of the 24-month period, which began on April 1, 1999. Claims not made within the 24 months will not receive federal matching funds and the state will not reimburse counties for the lost federal contribution. Entry of a "Y" on line "ZZ" and a "Y" on line H2 are sufficient for these claiming purposes.

Realistically, Phase 3 of the CMIPS IE to PCSP conversion will not occur within six months. The A&D FPL program and Y2K programming changes previously placed the IE to PCSP shift on hold. However, the IE to PCSP program changes now have priority. The special transactions are intended to provide an interim solution until the Phase 3 conversion.

With the start of Phase 3, CMIPS will calculate and compare two SOCs. At that time, the counties will need to comply with normal billing procedures and the two-year extension for the submission of claims will end.

Detailed instructions on these matters will be forthcoming in one or more ACLs. Questions regarding this letter can be directed to your IHSS/PCSP Bureau and Technical Assistance Unit at (916) 229-4000.

Sincerely,

Original Signed By
DONNA L. MANDELSTAM on 3/28/01

DONNA L. MANDELSTAM
Deputy Director
Disability and Adult Programs Division